

PROVIDER NAME _____

OPERATING CERTIFICATE #: _____ MMIS #: _____

WHOLE DOLLARS ONLY

A	B	C	D
DESCRIPTION	CURRENT MONTH	ADJUSTMENTS	ADJUSTED TOTAL
1. CASH FROM PATIENT CARE SERVICES	\$	\$	\$
2. OTHER CASH RECEIPTS (LIST)			
3. TOTAL OTHER CASH RECEIPTS	\$	\$	\$
4. TOTAL CASH RECEIPTS FROM ALL SOURCES (LINES 1 + 3)	\$	\$	\$
5. LESS: NON-ASSESSABLE CASH RECEIPTS (SCHEDULE A, LINE 7)	\$	\$	\$
6. ASSESSABLE CASH RECEIPTS (LINE 4 LESS LINE 5)	\$	\$	\$
7. ASSESSMENT RATE			.06
8. CURRENT MONTH ASSESSMENT (LINES 6 X 7)			
9. OTHER ADJUSTMENTS			
10. AMOUNT DUE (LINES 8 + 9)			
11. EXCESS CREDIT FOR FUTURE REMITTANCE			

CHECKS SHOULD BE MADE PAYABLE TO: HEALTH FACILITY ASSESSMENT FUND.

MAIL TO:

Regular Mail

MR JEROME ALAIMO
ASSESSMENT FUND ADMINISTRATOR
OFFICE OF POOL ADMINISTRATION
P O BOX 4757
SYRACUSE NY 13221-4757

Express or Overnight Mail

MR JEROME ALAIMO
ASSESSMENT FUND ADMINISTRATOR
OFFICE OF POOL ADMINISTRATION
344 SOUTH WARREN STREET
SYRACUSE NY 13202-2008